To: **Members of the Human Services Committee**

From: **Roberta J. Cook, President and CEO**

Re: **Human Services Committee Public Hearings on HB-5000, An Act Concerning Provider Audits Under the Medicaid Program**

Date: **March 13, 2014**

Senator Slossberg, Representative Abercrombie, Senator Coleman, Representative Stallworth, and distinguished members of the Human Services Committee, I thank you for your consideration of my testimony. My name is Roberta Cook and I am the President and CEO of BHcare, a regional nonprofit dedicated to improving the lives and health of the communities we serve by providing comprehensive behavioral health, prevention and domestic violence services. BHcare is designated as the Local Mental Health Authority for the towns of Ansonia, Branford, Derby, East Haven, Guilford, Madison, North Branford, North Haven, Oxford, Seymour and Shelton. Each year BHcare provides wraparound mental health and addiction services for more than 2700 Connecticut residents.

I am writing today in support of HB-5500, An Act Concerning Provider Audits Under the Medicaid Program. HB-5500 will strengthen the validity of Medicaid audits conducted by the Department of Social Services and the contractors acting on its behalf by limiting the extrapolation of claims to like claims rather than all claims billed by the provider; as well as eliminating payment based on the amount of overpayment deduced from the audit.

The current method for conducting audits, and the amount set aside in the state budget as revenue from Medicaid fraud and abuse ($64 million for FY 14 and $103 million for FY 15) is overly ambitious. I believe it is unrealistic, given that national data samples show actual fraud and abuse in the system to be fairly low. A 2013 survey by Pew Research found that the overall Medicaid fraud rate is 7%, and this figure includes mistakes such as clerical errors.

One of my main concerns is the practice of extrapolation, meaning using the results of a sample of claims that may have a clerical error (one not due to fraudulent actions of the provider, but reported to Medicaid nonetheless) and applying it to a larger population of claims. Currently the DSS and RAC audits use extrapolation as an automatic method by which to determine the number of payment errors and the amount of overpayments to collect from audited providers.

Here is an example from our 2010 audit:

TOTAL PAID CLAIMS	5,482
SAMPLE SIZE	100
SAMPLES WITH ERRORS	21
SAMPLE ERROR DOLLARS	$1,240.62
AVG $ ERROR/SELECTED CLAIM	$12.41
EXTRAPOLATED ERROR AMOUNT ($12.41 x 5,482)	$68,101.79

17 of the 21 errors mentioned above were clerical errors.

I greatly support section (d) of HB-5500 which stipulates that auditors only perform an extrapolation of claims based on a sample of like claims rather than the entire number of claims billed by a provider; this is a fair exercise of the practice of extrapolation.

My other major concern is the practice of paying contractors who perform DSS Medicaid audits on a contingency fee basis based on a percentage of payments they collect from providers. There is an inherent conflict of interest in this practice, as it allows auditors to benefit from the total amount of payments they collect from providers. One can conclude that there is an incentive to auditors to find evidence of wrongdoings or errors. I strongly support section (e) of HB-5500 as it resolves this conflict of interest by requiring that DSS not issue payment to a contractor based on the amount of overpayment determined by the audit.

I thank the Human Services Committee for paying attention to this important issue and for drafting a bill that addresses the issues with Medicaid audits in a fair and reasonable way, while still holding those guilty of fraud and abuse accountable for their actions.